MICHIGAN DEPARTMENT OF LICENSING & REGULATORY AFFAIRS
BUREAU OF COMMUNITY & HEALTH SYSTEMS
HEALTH FACILITIES DIVISION
SPECIALIZED HEALTH CARE SERVICES SECTION

OUTPATIENT PHYSICAL THERAPY- EXTENSION SITE QUESTIONNAIRE

Purpose: This questionnaire is intended for rehabilitation agencies (providers of outpatient physical therapy/speech therapy/occupational therapy) requesting Center of Medicare and Medicaid Services (CMS) approval of new extensions (locations, sites, units) furnishing physical therapy services. New extension locations may be subject to onsite inspection or survey. However, in the event no survey is conducted, the responses to this questionnaire plus supporting documentation will be used by the State Agency to make a recommendation to the Chicago Regional Office of CMS as to whether or not to approve the new extension.

Note: *This questionnaire should be completed for new extension locations that are operating and not those in the planning stage. When completing questionnaire, attach additional pages as needed.* ***Be sure to place your answers on the questionnaire, if needed, attach additional pages to complete the question.*** *If approved, the effective date will generally be whenever the first Medicare/Medicaid patient was provided services by the extension.*

Format: After solicitation of background information, the questions are arranged in order of the Conditions of Participation for rehabilitation agencies, found in 42 Code of Federal Regulations (CFR) 485.701-485.729 (Subpart H), a copy of which has been attached for reference.

Questions: If you have any questions about this process or completing the questionnaire, please contact:

Michigan Department of Licensing & Regulatory Affairs
Bureau of Community & Health Systems
Health Facilities Division, Specialized Health Care Services Section
PO Box 30664
Lansing, Michigan 48909
(517) 241-3830

Background:

1. Parent location name, address, telephone number, and Medicare provider number:

2. Name of rehabilitation agency administrator:

3. Name of individual assuming the role of the administrator when the administrator is absent plus a brief description of this individual's qualifications [42 CFR 485.709(b)(4)]:

4. Attach and label a copy of an organizational chart for the entire rehabilitation agency (including parent and all extensions) listing the names and titles of responsible individuals.

5. Provide the name and address of your Medicare fiscal intermediary:

6. Specify the agency's fiscal year end:

7. Attach and label a list of CMS approved parent and extension locations, including name (if different), complete address, telephone number, services provided at each location, plus the hours and days of operation for every location (parent or extension). (Physical therapy, speech pathology, and occupational therapy can be abbreviated as PT, SP, and OT).

8. Attach and label a list of **all** staff working at the parent location and any previously approved extension location. Give the person's name, title, function, and working hours for each location.

9. Proposed Extension Site Location (name, address, telephone number):

10. Attach and label a list of **all** staff working at the new extension location. Give the person's name, title, function, and working hours for the new location.

11. How many miles is the new extension located from the parent?

    What is the driving time between these locations?

    Explain any unusual conditions (urban congestion, road repairs, rural roads) which would affect the driving time:

12. Indicate which of the following services are furnished from the new extension either directly by agency employees or under a written contract.

	Directly	Under Contract
Physical Therapy	☐	☐
Speech Pathology	☐	☐
Occupational Therapy	☐	☐
Social/Vocational Rehabilitation	☐	☐

13. For **each** of the services being furnished at the extension location, please attach and label the following documentation for each employee providing services:

    a. Professional license number or certification number, if applicable
    b. Employment contract, if applicable per 485.717(a) or 485.719
    c. Qualifications
    d. Evidence of integration into the agency's activities (i.e., minutes of staff meetings)

14. Documentation from clinical records must be reviewed for **each** service being provided. Attach and label the following documented items/forms from each patient record submitted.

    a. Patient evaluation (i.e., history, diagnosis, need for treatment)
    b. All doctor's orders (initial plus updated)
    c. Plan of care (treatment plan)
    d. Progress notes and treatment records (from therapist, M.D., or other)
    e. Daily treatment log
    f. Discharge summary, if applicable

    Note: The above should consist of either open or closed (active or inactive) records for patients seen within the last 30-60 days. At minimum, attach three patient records for physical and occupational therapy, and two patient records for speech therapy. Please remove all patient identifiers from these records to preserve confidentiality.

15. How many active patients does the new extension have?

16. Where are the new extension services provided? Check all that apply.

    ☐ Extension location
    ☐ Patient's Residence
    ☐ Nursing Home
    ☐ Hospital
    ☐ Other (describe):

17. On what date was the first Medicare/Medicaid patient treated by the new extension?

QUESTIONS PERTAINING TO THE CONDITIONS OF PARTICIPATION FOLLOW:

Personnel qualifications (485.705)

18. What is the name of new extension supervisor/manager/administrator?

    Attach and label evidence of qualifications if this individual is functioning in any of the positions described by 42 CFR 485.705 Personnel quantifications.

Administrative management (485.709)

19. Furnish labeled copies of the table of contents or other list outlining your policies and procedures. Include date of last policy and procedure review and a roster of the review participants. Submit copies of any policies that are different for the new extension only.

20. Please explain how the organization functions with a common organizational structure and what is the reporting structure for the delegation of authority and communication with the extension site:

Plan of care and physician involvement (485.711)

21. Provide labeled copies of the extension site's procedures or describe (on attachment) the process for establishing a care plan, including:

    a. How physician's orders are obtained
    b. How the patient's medical history and prior treatment is obtained
    c. Who furnishes the plan of care? (an MD, physical therapist, speech pathologist)
    d. Components of the care plan
    e. How care plans are reviewed.
    f. How care plans are updates/changed

22. Provide the name, address, and phone number of the physician(s) available to the extension to furnish medical care in case of emergency:

Physical therapy services (485.713)

23. Specify which physical therapy modalities are available.

24. Attach and label an inventory of patient care equipment that is available for use at the extension site, signed by the agency administrator.

25. Furnish the log of equipment safety checks and calibration [485.723(b)(1)]. (If equipment is new, furnish the date of purchase, date of installation, and written assurance signed by the administrator that the equipment is operating properly and safely).

26. Explain how physical therapy services furnished at the extension will be supervised by a physical therapist during all operating hours [485.713(c)] (attach and label additional pages if needed):

27. Explain how supportive personnel will be instructed [485.713(d)]. Submit training and competency checklist indicating date of training, competency evaluation, and supervising therapist (attach and label additional pages if needed).

Occupational Therapy Services

Note: Although there are no regulations specifically written for outpatient occupational therapy services, the qualifications of the persons you identified as providing these services will be evaluated with respect to the definitions of occupational therapist and occupational therapy assistant found at 484.4. Services must also be furnished in accordance with the requirements in 485.713(c) & (d).

28. Attach and label a brief description of the program of occupational therapy you plan to provide.

    a. The diagnostic and treatment services you plan offer
    b. The types of disorders you plan to treat
    c. The equipment available to treat these disorders
    d. Preventative maintenance of equipment (485.723), if applicable

29. Where will services be provided? Check all that apply:

    ☐ Extensive location
    ☐ Patient's home
    ☐ Nursing home
    ☐ Hospital
    ☐ Other (specify):

30. Do the occupational therapists cover more than one location? Check one.

    ☐ No
    ☐ Yes

31. Explain how the number of qualified occupational therapists and occupational therapy assistants will be adequate for the volume and diversity of occupational service anticipated (attach and label additional pages if needed):

32. Explain how you will ensure that a qualified occupational therapist is on the premises or readily available during all operating hours of the organizations (attach and label additional pages if needed).

33. If supportive personnel are available to assist occupational therapists with services incident to occupational therapy, explain how these personnel are instructed by qualified occupational therapist who retain responsibility for the treatment plan prescribed by the attending physician.

Speech pathology services (485.715)

34. Explain your program of speech pathology by attaching a list of the following:

    a. The diagnostic and treatment services you plan to offer
    b. The types of disorders you plan to treat
    c. The equipment available to treat these disorders
    d. Preventative maintenance of equipment (485.723), if applicable

35. Where will services be provided? Check all that apply:
    ☐ Extension location
    ☐ Patient's home
    ☐ Nursing home
    ☐ Hospital
    ☐ Other (specify):

36. Do the speech therapists cover more than one location? Check one.

    ☐ No
    ☐ Yes

37. Explain how an adequate number of qualified personnel and equipment will be available for the range of disorders and number of patients which you plan to treat:

38. Explain how you will ensure that there is at least one qualified speech pathologist present at all times when speech pathology services are furnished.

Rehabilitation program (485.717)

39. Check which type of rehabilitation services are provided by the extension.

    ☐ Social adjustment services
    ☐ Vocational adjustment services

40. If applicable, explain/describe how social/vocational services are provided to nursing home residents receiving therapy. Submit and label written agreements established with the nursing home.

41. If applicable, explain how this individual provides rehabilitation services to multiple locations. Indicate the day and hours that this individual is on-site at each location.

42. Describe how this individual functions within the rehab agency "to evaluate the social and vocational factors, to counsel and advise on the social or vocational problems that arise from the patients' illness or injury, and to make appropriate referrals for needed services". (Describe in detail when and how these evaluations are performed and how appropriate agency staff are advised of findings and treatment plan-attach and label additional pages if needed).

Clinical records (485.721)

43. Describe how clinical records are protected, indexed, and physically maintained. Indicate the location of these records on the floor diagram requested under physical environment. Describe the manner in which extension site clinical records are distinguishable from the parent location.

Physical environment (485.723)

44. Check the type of building which you occupy:
☐ Stands alone (houses the extension only)
☐ Part of a larger building
☐ Part of another Medicare provider (i.e. nursing home). Specify by Medicare provider number, name, and complete address:

45. Describe the building. For instance, you might respond that the extension occupies a suite on the second floor of a three-story commercial building or a room/rooms within a nursing home.

46. Provide a floor diagram locating the extension within the building and illustrating the pathway of entrance and exit. Does this passageway provide adequate width for movement including non-ambulatory patients; is it free from obstructions at all times, and are stairwells equipped with firmly attached handrails, at least on one side? Yes ☐ No ☐ If no, describe any deficiencies and plans for remedying the deficiencies.

47. Provide a diagram of the space occupied by the extension, drawn to scale, locating all rehab equipment and furniture.

48. Check how you control the extension space.
☐ Own
☐ Rent (attach and label a copy of the lease)

49. What was the date of the last fire inspection of the building?

Attach evidence of approval by the fire authority having jurisdiction. If located within another Medicare provider, obtain and attach the results of the last Life Safety Code survey.

Infection Control (485.725)

50. Explain the manner by which the rehab agency's Infection Control Committee monitors the extension site operation, including the housekeeping, linen, and pest control operations.

Disaster preparedness (485.727)

51. Attach a copy of the disaster plan for the extension. Describe the content and dates of training given to extension staff and the dates of any drills conducted at the extension. Include signed roster of participants (name and title/position).

Program evaluation (485.729)

52. What was the date of the last clinical records review?

Did it include a sample of open and closed record from the extension? Yes ☐ No ☐ Include signed roster of participants (name and discipline).

Written Attestation

53. Please have the administrator sign this questionnaire attesting that:

a. The policies established for the rehabilitation agency are in effect and a copy is on site at the extension location, and
b. After reading section 485.723 careful, that: "All physical environment requirements are met such that the building housing the extension is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and providers a functional, sanitary, and comfortable environment", and
c. All of the information provided herein and documentation attached is true and accurate, and
d. As administrator, I will ensure that all Medicare regulations will be met at all times at the new extension.

Signature: _____

Print Name:

Date questionnaire completed:

Thank you for your time and cooperation. A representative of your State agency will contact you, if there are any questions prior to forwarding a recommendation to CMS (Chicago Regional Office).